BEFORE THE DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
GILBERT J. ELIAN, M.D.	)	**File No: 03-90-638**
Certificate # G-26558	)	
Respondent.	)	

DECISION

Pursuant to the Order Vacating Prior Judgement Granting Peremptory Writ of Mandamus; and New Judgement Denying Peremptory Writ of Mandamus Following Remittitur Notice, filed in the Los Angeles County Superior Court on March 10, 1995, the effective date of this Decision, which was originally ordered on May 21, 1992, shall be April 21, 1995.

DATED March 23, 1995 .

DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA

Ira Lubell, M.D.
Division of Medical Quality

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
GILBERT J. ELIAN, M.D. 4585 Stevens Creek Blvd., #100 Santa Clara, CA 95050 Certificate No. G26558	)	Case No. D-4090 OAH No. N 35794
Respondent.	)	

DECISION

The Division of Medical Quality non-adopted the Proposed Decision of Administrative Law Judge Robert R. Coffman and proceeded to decide the case itself upon the record, including the transcript.

The parties were afforded the opportunity to present written and oral arguments to the Division itself.

Having considered the entire matter, the Division now makes this decision.

The Division adopts the attached Proposed Decision of the ALJ as its decision in this case, except for the following amendments, additions, and modifications:

1. On pages 2 and 14 of the Proposed Decision, the word "phobia" should be spelled "fovea".

2. The Division adds Findings of Fact XVI, as follows:

XVI

Respondent testified he would advise these five patients that they had a cataract and offer them surgery were they to walk into his office the next week after the hearing, even if the opacity were not as severe as he originally indicated.

Respondent employed a bonus or "profit sharing plan" for employees based on the number of surgeries performed by Respondent.

The public needs to be adequately protected.

3. Outright revocation of license is the Division's order in this case. The Division adopts all of the "Order" appearing only on page 27 of the Proposed Decision providing for five separate revocations based on five separate determinations, as set forth in paragraphs 1. through 5.

The Division does not adopt the Stay of Revocation, or the Order for Probation, or the terms and conditions for probation. Thus, the Division deletes and strikes all provisions on pages 28, 29 and 30, with the intent that the license be unconditionally revoked, separately and severally.

The effective date of this Decision shall be June 20, 1992.

SO ORDERED May 21, 1992

MEDICAL BOARD OF CALIFORNIA
Division of Medical Quality

By Theresa L. Claassen
THERESA L. CLAASSEN
Secretary/Treasurer

DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
GILBERT J. ELIAN, M.D. Certificate No. G-26558	)	No. D-4090 N-35794
Respondent.	)	

ORDER DELAYING DECISION

Pursuant to section 11517(d) of the Government Code, the Division of Medical Quality, finding that a further delay is required by special circumstances, hereby issues this order delaying the decision for no more than 30 days from April 21, 1992 (when the 90-day period expires) to May 21, 1992.

The reason for the delay is as follows: This case is on the agenda for the Division's meeting on May 7, 1992. Therefore, the Division needs additional time to re-draft the decision and to effect service on the parties.

DATED: April 16, 1992

VERNON A. LEEPER
Chief - Enforcement

BEFORE THE DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	No. D-4090
GILBERT J. ELIAN, M.D. Certificate No. G-26558	N-35794
Respondent.	NOTICE OF NON-ADOPTION OF PROPOSED DECISION

NOTICE TO ALL PARTIES:

YOU ARE HEREBY NOTIFIED that the Division of Medical Quality voted not to adopt the proposed decision recommended in this case. The Division itself will now decide the case upon the record, including the transcript.

To order a copy of the transcript, please contact the Transcript Clerk, Office of Administrative Hearings, 455 Golden Gate Ave., San Francisco, CA 94102 (Room 2248).

After the transcript has been prepared, the Division will send you notice of the deadline date to file your written argument. Your right to argue on any matter is not limited. The Division is particularly interested in arguments on the following: Why the penalty should not be reconsidered.

In addition to written argument, oral argument may be scheduled if any party files with the Division within 20 days from the date of this notice, a written request for oral argument. If a timely request is filed, the Division will serve all parties with written notice of the time, date and place of hearing.

Please remember to serve the opposing party with a copy of your written argument and any other papers you might file with the Division. The mailing address of the Division is as follows:

Division of Medical Quality
Medical Board of California
1426 Howe Avenue
Sacramento, Ca 95825
(916) 920-6393

Dated: September 16, 1991

DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA

BY Vernon A. Leeper

VERNON A. LEEPER
Chief - Enforcement

Rev: tb:3/90

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
GILBERT J. ELIAN, M.D. 4585 Stevens Creek Blvd., #100 Santa Clara, CA 95050 Certificate No. G26558	)	Case No. D-4090 OAH No. N 35794
Respondent.	)	

PROPOSED DECISION

This matter was heard before Robert R. Coffman, Administrative Law Judge, Office of Administrative Hearings, State of California in San Francisco on November 6, 1990, May 13 and 28, 1991; and in San Jose on November 13, 14, 15, 16, 19, 20, 28, 1990, May 6, 7, 8, 9, 10, 14, 15, 16, 17, 20, 21, 22, 23, and 24, 1991.

Russell W. Lee, Deputy Attorney General, represented the Medical Board of California.

Respondent was present and was represented by Louis C. Castro, Attorney at Law.

FINDINGS OF FACT

I

Kenneth J. Wagstaff made the Accusation, First Supplemental Accusation, and Second Supplemental Accusation in his official capacity as the Executive Director of the Medical Board of California.

II

At all times material herein respondent Gilbert J. Elian, M.D., has held physician and surgeon certificate No. G26558,

which was issued to him on or about April 2, 1974. No prior disciplinary action has been taken against respondent's certificate and the certificate is in good standing at the present time.

III

Respondent is a Santa Clara general ophthalmologist. Until sometime in 1990 the emphasis of his practice was on performing cataract surgery. In this matter respondent is charged with scheduling unnecessary cataract surgery for the six patients discussed in Findings V through X herein.

IV

There may be some exceptions to the following standards and definitions but any exceptions or qualifications are not pertinent to this matter and therefore are not included.

(a) For vision to occur light must pass through the lens of the eye to the retina which relays the image to the brain. The function of the lens is to focus light rays onto the retina. Cataracts can affect vision by distorting the light ray passing through the lens.

Reduced vision may also be due to a deterioration of the macula, the central area of the retina. The retina is the inner area of the eye, necessary for vision. The macula is the central area of the retina and is critical to good vision, particularly central vision. The phobia is the center of the macula. Macular degeneration is not reversible. Severe macular degeneration can lead to complete loss of central vision.

(b) A cataract may be defined as any opacity or cloudiness of the lens of the eye, but is more appropriately defined as any opacity of the lens that prevents a clear image from forming on the retina, or an opacity that produces impaired vision.

Opacities most commonly occur in the central core or nucleus in association with aging. Nuclear sclerotic cataracts generally progress slowly over a period of years. Cataracts can only be removed by operative surgery. The surgeries scheduled by respondent in this matter were extracapsular cataract surgeries with intraocular lens implants using the phacoemulsification technique.

(c) Cataract surgery is elective. The standard of practice is that when cataract surgery is appropriate the ophthalmologist may offer it to the patient. The patient should never be urged or pressured to undergo cataract surgery. For that reason it is seldom recommended by the ophthalmologist, but is offered as an option to the patient.

(d) The standard of medical practice in California is that cataract surgery may be performed when the following exist:

1. An opacity or other abnormality of the lens resulting in the patient's decrease in visual acuity must be present that is consistent with the patient's inability to function in his/her daily living pattern, lifestyle, occupation and desired or required activities. The patient must feel the cataract is interfering with her/his lifestyle, that the patient's lifestyle is significantly impaired. This should be documented by the ophthalmologist with a history setting forth the patient's problems in his/her daily activities, employment, or recreation; and

2. Best corrected visual acuity in the eye to be operated on must be 20/40 or worse. (This has been changed to 20/50, but the relevant standard, applicable in 1989, was 20/40 or worse); and

3. The patient's desire and consent for surgery and a reasonable expectation of improved visual function must be documented by the ophthalmologist.

(e) While all three major types of cataracts, nuclear sclerotic (NS), cortical and posterior subcapsular (PSE), are relevant to this proceeding, most of the patients had either NS cataracts or age related nuclear sclerosis (NS). With age some NS develops in the lens. Such NS changes can be mild or minimal and are not properly considered cataracts. The individual can see perfectly clearly but the lens is not perfectly clear. Some ophthalmologists might refer to such changes as cataracts or might feel that a cataract is beginning to develop, but such changes may never develop into a cataract. However mild NS changes are characterized, it is not within the standard of practice to perform cataract surgery on individuals with such mild NS changes. In many cases cataract surgery under such circumstances would be an extreme departure from the standard of practice.

(f) Nuclear sclerotic cataracts and age related nuclear sclerosis are rated by ophthalmologists on a 1 to 4 scale as follows:

1+ NS -- Minimal nuclear sclerotic changes; not a cataract; does not affect vision.

2+ NS -- A mild cataract which may or may not affect the individual's vision, but usually does not significantly affect one's vision.

3+ NS -- A moderate cataract; usually means a visually significant opacity.

4+ NS -- An advanced cataract. The nucleus is extremely dense, the lens is very cloudy or opaque.

(g) Complications of cataract surgery and lens implantation include the following: complications due to anesthesia, infection, hemorrhage, detachment of the retina, dislocation of the lens, iris atrophy, uveitis, loss of corneal clarity, glaucoma, and macular edema. Complications can result in a decrease in vision and a total loss of vision. The risk of losing all vision is approximately 2% to 3%. Macular edema occurs in 30% to 60% of such patients as a temporary condition and in about 2% as a visually significant permanent problem.

V

Sometime shortly before August 31, 1989, T.H., an 81 year old woman, underwent a vision or cataract screening by the Cataract Institute of California, one of the names used by respondent in his practice. The screening was performed by one of respondent's technicians at a senior citizen residence center where T.H. worked and lived. The screening included having T.H. read a vision chart (a standard Snellen eye chart that tests visual acuity from 20 feet) and a near vision card. T.H. did not attend the screening because of any complaint about her vision; she had none. She went because it was free.

The technician prepared a Screening Information Sheet which includes five questions calling for a yes or no answer, and a comments section for the technician's findings. A similar form was used in all the screenings involved in this matter. The technician listed T.H.'s vision at 20/20 (right eye) and 20/20 (left eye). Where visual acuity is referred to the first reference is to the right eye, the second is to the left eye. The technician listed T.H.'s near vision as 20/30 and 20/40. Near vision is tested by having the individual read from a near vision test card, holding the card approximately 14 inches from the eyes. Respondent uses distance designations (20/20) to record near vision. Many ophthalmologists record near vision by reference to the Jaeger reading card, shortened to J-1, J-2, J-3, et seq., representing the lines on the reading card. Several companies have developed near vision cards that are

used by ophthalmologists. Not all are identical, so J-1 on one card may be slightly smaller print than J-1 on another card. The same holds true where 20/20 is used to record near vision. The cards in evidence, Exhibits U, V and 7, are similar as to J-3, J-4 and J-5. The Titmus card's J-1 print appears to be slightly larger than the 20/20 equivalent on respondent's cards (Exhibits U and V). The 20/20 equivalents on respondent's cards are extremely fine print not ordinarily encountered in anyone's daily activities. For purposes of this proceeding the differences between the cards are not significant in that anyone who can read J-1 on the Titmus card can readily read 20/30 and probably 20/25 on respondent's cards.

Respondent's technician told T.H. she should go to respondent's office for an eye examination. She went because it was free (or paid for by Medicare) and respondent provided free transportation.

Respondent examined T.H. in his office on August 31, 1989. Respondent's technician tested her visual acuity, including a manifest refraction with an instrument used to determine her best corrected vision. Respondent then performed a clinical examination including a slit lamp examination. T.H. was again found to have 20/20 vision in each eye. Her near vision was recorded at 20/30 and 20/40. Respondent found that she had cataracts in each eye. He recorded the cataracts as 6/10 NS, using his own 1 to 10 scale. Such a scale is not used by other ophthalmologists. The universal standard within the profession is a 1+ to 4+ rating system for NS cataracts, with a few ophthalmologists using a 5+ for a cataract so severe it is rarely seen. Respondent's 6/10 is equivalent to slightly over a 2+ NS cataract.

At the August 31 visit respondent or one of his employees told T.H. she had a cataract which had to be removed. On the same visit T.H. signed respondent's consent form for cataract surgery with intraocular implant, which was scheduled for September 21, 1989.

Shortly after August 31 T.H., upon a relative's recommendation, sought a second opinion and on September 8, 1989 was examined by Peter D'Alena, a San Jose ophthalmologist who found her visual acuity 20/25 and 20/25+1, and J-4 and J-1. He found minimal NS in each eye, told T.H. she had no cataracts and recommended against cataract surgery.

On August 30, 1990 T.H. was examined by two San Francisco ophthalmologists, John Stanley and William Spencer, at the request of a representative of the Board. Dr. Stanley found minimal NS, 1+NS, in each eye but no cataracts. Dr. Spencer found no cataracts and a 1+NS in each eye. Dr. Spencer and

Dr. Stanley got her far vision at 20/25+1 and 20/25. Both found her near vision to be J-1 in each eye and when her prescription was improved by refraction she read at a rapid J-1, the finest print on the reading card. The 1+NS Dr. Stanley and Dr. Spencer found was part of the normal aging process, not a cataract.

When seen by respondent on August 31, 1989 the only complaint T.H. had about her vision was "difficulty in reading fine print." Her only complaint when seen by Dr. D'Alena on September 8, 1989 was a "little trouble reading small words." On August 30, 1990 when seen by Dr. Spencer and Dr. Stanley, T.H. had no visual complaints whatsoever, including any near vision or reading complaints.

T.H. testified in this proceeding on November 16, 1990. She drives during the day and night, knits, reads newspapers, magazines, and the telephone book without difficulty. She has absolutely no complaints about her vision. She is employed as a receptionist.

Evidence was clear that offering cataract surgery to T.H. without first ascertaining the importance to her of reading fine print and her desire to improve her near vision, was an extreme departure from the standard of practice. Respondent clearly failed to make such determinations. "Difficulty in reading fine print" is not enough to justify cataract surgery. At least two of the experts called by respondent, Dr. Kroll and Dr. Farber, agree that this is not a sufficient basis for scheduling cataract surgery. At least two of the experts called by respondent, Dr. Farber and Dr. Hoffer, would not perform cataract surgery on T.H. because her vision is 20/20 and an attempt should first be made to increase the strength of her bifocals.

Respondent's experts did not think respondent's conduct was an extreme departure from the standard of practice, based on respondent's finding of a significant cataract and the patient's desire for surgery to correct the reading "difficulty" found by respondent. Because none of these factors in fact existed: a significant cataract, a reading difficulty of importance to T.H., and T.H.'s desire to correct the deficiency through cataract surgery, the testimony of such experts is of little or no significance on the question of respondent's negligence or gross negligence.

Only Drs. Elian, D'Alena, Spencer and Stanley examined T.H. Drs. Spencer and Stanley testified in this proceeding. Their credibility was excellent and their ethics of the highest standard. They found no cataracts and no reading problem justifying surgery even if T.H. had a cataract. Their observations are corroborated

by T.H. herself and by Dr. D'Alena. The latter did not testify but his medical records are in evidence. It should also be noted that even if T.H. tested J-4 in one eye and J-1 in the other, her vision would be J-1 when reading with both eyes.

Respondent has attempted to justify his conduct in scheduling cataract surgery for T.H. by (1) relying on the results of an opacity lens meter, a relatively new machine which respondent asserts objectively measures the density of cataracts, and (2) he contends T.H. told him she had difficulty reading prescription medication bottles. The latter is found no where in the records, including respondent's records, and is inconsistent with the other evidence in this matter as set forth in the above Findings. Such contention is not consistent with T.H.'s testimony. T.H. is a bright, alert individual with good credibility. Significantly, she was not questioned at all on cross-examination about her ability to read medication labels and/or whether she told respondent anything about reading labels. Parenthetically, it is noted that the printing or typing on prescription bottle labels is generally in large print. Some nonprescription containers do contain small print, but evidence did not establish that that was a complaint of T.H.'s and clearly did not establish that it was important enough to her lifestyle that she was willing to undergo surgery in an attempt to improve her ability to read such print. As to the lens meter, other than respondent not one of the 12 ophthalmologists who testified in this matter use such instrument. Evidence established that it is a new device whose reliability has not been established, at least for the purpose relied upon by respondent, particularly in attempting to measure cataracts in 80 year olds. In addition, the lens meter is not needed because ophthalmologists can better and easier determine the opacity in the lens by clinical examination. In this case the lens meter registered a more significant opacity in T.H.'s right eye than her left, but respondent found her visual acuity in the right eye to be perfect (20/20) and her near vision almost perfect (20/30 on a card where 20/20 is extremely fine print). Cataract surgery on an 81 year old with such perfect or near perfect vision is obviously not warranted. Respondent's machine is either unreliable, or the operator unreliable, or the correct reading was not recorded. Of more significance than the lens meter is the fact that NS cataracts get progressively worse over time, causing a decrease in visual acuity. Respondent examined T.H. in August 1989. In August 1990 she had no complaints or cataracts and still no complaints in November 1990, 15 months after respondent's examination.

The question on T.H.'s screening information sheet asking "Do you have blurred or cloudy vision" is checked "yes." However, the handwriting on the document is not T.H.'s. In addition, a notation of blurred vision without determining the nature, extent, circumstances and details surrounding such

vision is not a complaint or finding on which a decision to perform cataract surgery may be based. The information on respondent's screening information sheets and his personal history forms are questionable at best, see Finding XV(b).

Respondent's conduct in scheduling cataract surgery for T.H. was an extreme departure from the standard of practice of medicine in that T.H.'s visual acuity was perfect or near perfect, she had no cataracts, and she had no complaints that would warrant cataract surgery.

VI

Shortly before April 18, 1989, J.L., an 88 year old male, participated in one of respondent's vision screenings, performed by one of respondent's technicians. No visual complaints at all are listed on the Screening Information Sheet. The technician listed J.L.'s visual acuity at 20/25 and 20/50 and arranged for J.L. to be examined at respondent's office on April 18, 1989.

Respondent examined J.L. in his office on April 18, 1989. His visual acuity was listed at 20/25 and 20/60. Respondent found that J.L. had a 3+NS cataract in each eye and scheduled cataract surgery for the left eye.

Respondent's examination record includes a "Complaint" section where patient's visual complaints are listed. On J.L.'s examination record the only notations under that section are that the patient was told that he might have a cataract, left eye, states that he sees well with current prescription, and is afraid he might not pass DMV test. Expert evidence clearly established that fear of not passing the DMV test is not a complaint that would justify cataract surgery. J.L.'s Screening Information Sheet indicates his last eye examination was 12 years ago, that he does not have blurred or cloudy vision, and that he has never been told by a doctor that he has cataracts. If J.L. was told he might have a cataract, it can be inferred it was by respondent or one of respondent's employees as there is no evidence he saw any health care practitioner in the short interval between the screening and April 18. If he was told he had a cataract, irrespective of who may have told him, it is not a complaint and certainly not one that would justify cataract surgery.

On April 25, 1989 Dr. Armand Bigler, an internist, saw J.L. and J.L.'s wife for pre-operative physicals. Dr. Bigler felt J.L. had faint cataracts because J.L's fundus did not appear totally clear to him. He advised J.L. to obtain a second opinion before undergoing cataract surgery.

On June 12, 1989 Dr. Lee Shahinian, a Mountain View ophthalmologist, examined J.L. and found his visual acuity 20/25 and 20/50. He found no cataracts and no significant NS or lens opacity. He found less than 1+NS.

On July 20, 1989 Dr. John Stanley, the San Francisco ophthalmologist referred to in Finding V, examined J.L. and got his visual acuity at 20/20 and 20/50 and his near vision at J-1. Dr. Stanley found no cataracts and very minimal NS, 1+NS or less. J.L. had absolutely no visual complaints. He was still driving and could read the finest print.

In June 1990 Dr. Mary Ellen Paquette, a Mountain View ophthalmologist, examined J.L. and found that he had a very clear lens with less than 1+NS, and no cataracts.

Three ophthalmologists examined J.L. and found no cataracts. Two found a crystal clear lens, the other found very minimal NS. One of these ophthalmologists examined J.L. more than a year after respondent's exam, when any opacity of the lens would be expected to have increased. This is overwhelming evidence that J.L. had no cataracts and no visual complaints. Ophthalmologists can differ as to the exact degree of NS present, but not a difference of 1+ versus 3+. A 1+ is not a cataract, a 3+ is a significant cataract. With a 1+NS the fundi can be seen very clearly, but with a 3+NS the fundi is cloudy and difficult to see. In scheduling J.L. for cataract surgery respondent was guilty of an extreme departure from the practice of medicine.

Respondent claims J.L. told him everything he saw out of his left eye was blurry. This complaint is not listed on respondent's examination record and is completely inconsistent with the overwhelming weight of the evidence. Respondent's claim is not at all credible. In addition, "blurry vision" in itself, without explanation or more detail, is not justification for cataract surgery. Assuming that J.L. had significant cataracts, the criteria for surgery, patient complaints of inability to function in his lifestyle or a significantly impaired lifestyle, was not established.

VII

Shortly before April 18, 1989, H.L., the 91 year old wife of J.L., participated in one of respondent's cataract screenings conducted by one of respondent's technicians who recorded her visual acuity at 20/40 and 20/50. She reported no visual complaints or problems and the technician listed none on the screening sheet.

On April 18, 1989 respondent examined H.L. in his office. Her visual acuity with her glasses was listed as 20/80 and 20/25, but she was refracted to 20/60 and 20/25. Respondent recorded a 3+NS cataract and a 3.5NS cataract. Recorded under the Complainant section of respondent's examination record was "eyes don't hurt and she can see to read with her glasses."

On April 25, 1989 Dr. Bigler examined H.L. and found that her lens looked crystal clear. She asked Dr. Bigler if she really needed cataract surgery as she could see very well. Dr. Bigler called the respondent and asked what he detected in the way of cataracts. Dr. Bigler's record of the conversation was as follows: "He was immediately angry and abusive. He said 'what field are you in? Her vision is 20/80. My test shows she can be 20/20 with implants. I didn't send her (to you) for a second opinion. I sent her for an examination. I don't appreciate an internist telling me how to run my business. Comprende?'"

Dr. Bigler referred H.L. for a second opinion and she accompanied her husband J.L. to Dr. Shahinian's office on June 12, 1989. She informed Dr. Shahinian that she was told she needed cataract surgery, but she felt her vision was fine. She didn't want to be examined by Dr. Shahinian that day. On July 19, 1989 at Dr. Shahinian's office she advised the doctor that she had no eye complaints and did not desire an examination. However, she consented to a brief, informal exam. Dr. Shahinian found her visual acuity at 20/50 each eye with her current glasses. He did not refract her. He noted that she had no significant lens opacity.

On July 20, 1989 H.L. was examined by Dr. John Stanley. She had no visual complaints. Dr. Stanley refracted her to 20/40 and 20/40. She had no cataracts. She had mild or 1+NS, both eyes.

Respondent cannot remember H.L. but claims that she told him she had blurry vision. Such claim is not credible. Respondent also claims the personal history questionnaire form on which someone circled "yes" to the question "Do you now have or have you ever had .... blurred vision," was enough for him to conclude she had complaints justifying cataract surgery. Respondent's claim is without merit for the reasons expressed in the above Findings and is illustrative of his persistent unwillingness to follow the criteria for cataract surgery. In addition, respondent's personal history form cannot be relied upon in evaluating patients because it is not limited to a present complaint, but states "have you ever" experienced blurred vision. Individuals may have experienced blurred vision at one time or another during their life but may not have any present lens opacity, e.g., from medication, from an object lodged in the eye, an eye infection, a concussion or blow to the head,

while ill with fever, seasickness, migraine, or a myriad of other reasons including a need for new glasses. Respondent's technician states she would follow up with questions of a patient who listed blurred vision on the form, such as when (while driving, reading, etc.), the frequency and other details, and would record such information on the examining page of the patient record. Respondent also testified patient complaints are recorded on the examining page. Not only was that not done with H.L., it was not done with J.L. and T.H. (except for the "small print" notation).

Evidence very clearly established that H.L. did not have a cataract and had no visual complaints that would justify cataract surgery. H.L. could not have had 3+NS and 3.5+NS cataracts that two other ophthalmologists could not detect. A 3.5NS cataract is a quite dense opacity that an experienced ophthalmologist cannot miss. Respondent's conduct in scheduling H.L. for cataract surgery was an extreme departure from the standard of practice of medicine.

VIII

Approximately May 1989, H.D., an 86 year old woman, attended one of respondent's screenings. The technician listed her complaints as hazy vision each eye, distance and near. The technician got her visual acuity with her glasses at 20/40 and 20/50 and her near vision at 20/30 and 20/30. She was referred to respondent for an eye examination.

On May 10, 1989 respondent examined H.D. in his office and obtained a visual acuity of 20/40 and 20/30 with her glasses. There was no change with refraction. Respondent found cataracts of 2.5+NS and slightly more than 2+NS. Near vision was listed at 20/50 and 20/50. No near refraction was done. Respondent's examining record indicates complaints of blurred vision distance and near, and glasses never been correct. On the same office visit respondent scheduled H.D. for cataract surgery on her right eye.

In April 1989, during a physical examination, H.D.'s internist noted early cataracts but that H.D. was having no trouble with her vision. In May when H.D. reported to the same internist that respondent had scheduled her for cataract surgery, he recommended she see her regular ophthalmologist, Dr. Mary Ellen Paquette.

On May 18, 1989 Dr. Paquette examined H.D. and found her visual acuity at 20/40 and 20/30, refracted. Her near vision was J-2 and J-1. H.D. stated she had blurred vision and didn't like her glasses, but during a discussion with Dr. Paquette about all her activities it was determined her vision did not

interfere with any of those activities, including driving and reading. Dr. Paquette concluded that H.D. had no visual complaints that interfered with any of her daily activities. Dr. Paquette found mild cataracts in each eye, 2+NS cataracts, and determined that cataract surgery was not indicated. H.D. reported to Dr. Paquette that she did not want cataract surgery and felt pressured by respondent to agree to surgery.

Dr. Paquette testified in this proceeding. She was a reliable reporter of H.D.'s condition, including visual complaints and denial of such complaints that affected her lifestyle.

Respondent's conduct in scheduling H.D. for cataract surgery was unnecessary and a departure from the standard of practice in that she had a mild cataract that resulted in a very mild impairment of her vision. Her cataracts did not significantly impair her vision. Cataract surgery would produce no significant benefit to H.D. Her complaints did not justify cataract surgery in that they did not significantly interfere with her activities or lifestyle.

IX

On June 28, 1989 respondent examined H.S., an 85 year old woman who had earlier gone through one of respondent's screenings at a senior citizen residence. Respondent's records indicate that her vision was count fingers (CF) and 20/60. Diagnosis was cataracts and macular degeneration both eyes, including a 3.5+NS cataract in the left eye. On the same day she was scheduled for cataract surgery on her left eye.

Earlier in the year, approximately February 1989, H.S.'s internist referred her to Dr. David Chang, a San Jose area ophthalmologist, for an ophthalmological examination. Dr. Chang found her visual acuity to be CF and CF, with a 2+NS cataract in her left eye. Dr. Chang is of the opinion that her extensive macular degeneration is the cause of the vision loss in her left eye.

On April 29, 1988 Dr. Roderick Biswell, a San Jose ophthalmologist, recorded the visual acuity in her left eye at 20/50, but by August 8, 1989 it had dropped to 20/200. Such a sudden decrease in vision is a strong indication that the cause is a retinal problem rather than a cataract.

Macular degeneration is a retinal problem causing loss of vision. The macular degeneration in H.S.'s right eye is so severe that she has extremely limited vision in that eye. Cataract surgery would not improve her vision in that eye. The evidence is in conflict on the question whether cataract surgery would improve the vision in her left eye. But expert evidence established that any such improvement would likely range from

zero to 15%. Cataract surgery could make clearer the area of her present limited vision, making more light available in that area. Dr. Howard Schatz, a retinal specialist testifying for respondent, agrees with Dr. Chang's description of the improvement H.S. could experience with cataract surgery, that her vision would be similar to looking through a straw.

On July 21, 1989, at the request of Drs. Chang and Elian, H.S. was examined by Dr. Sterling Haidt, a San Jose area ophthalmologist and retinal specialist. Dr. Haidt found mild NS changes in both eyes and in the left eye marked atrophy in the macular area. It is Dr. Haidt's opinion that the vast majority of the visual loss in the left eye is secondary to atrophic macular degeneration. In April 1990, at respondent's request, Dr. Haidt wrote to respondent, stating in part that "it is impossible to exactly determine the proportion of visual loss secondary to each etiology (the macular degeneration and the NS)." The letter is not part of the medical records in evidence in this matter and should not be accorded the same weight as Dr. Haidt's records that are included in Exhibit 3 in evidence. Dr. Haidt did not testify in this proceeding. Assuming the letter is more than hearsay, a careful reading of that document does not indicate that Dr. Haidt is changing his opinion that the vast majority of the vision loss is caused by macular degeneration. Dr. Haidt was very careful to couch the language in his letter, "to exactly determine," so that it does not expressly repudiate his earlier opinion; it is not inconsistent with his opinion set forth in the medical records.

On May 6, 1991 Dr. Joseph Farber, a San Leandro ophthalmologist examined H.S. pursuant to respondent's request. Respondent selected Dr. Farber who testified on respondent's behalf in this proceeding. Dr. Farber found her visual acuity CF and 20/80. He initially got her left eye at 20/200, but he pressed her for about ten minutes to read more lines on the chart and eventually got her at 20/80 refracted. In Dr. Farber's opinion she would not be able to read except with good light and a magnifying glass even after cataract surgery. He is of the opinion the best increase in vision that could be hoped for would be in the neighborhood of 15%. He is of the opinion that it is below the standard of care to inform H.S. that cataract surgery would drastically improve her vision, that that would represent an unrealistic expectation. Dr. Farber would tell H.S.'s family that she has significant macular degeneration but if they want to take the risk of cataract surgery, with a complication rate of about 5%, for a small improvement, he would do the surgery.

Dr. Schatz's opinion is mostly consistent with Dr. Farber's. Dr. Schatz believes cataract surgery for H.S is not contraindicated if the cataract is bad enough and she has a functioning retina. In his opinion the angiogram indicated

"phobial sparing," meaning a likelihood she has a functioning phobia. But Dr. Schatz is also of the opinion that because H.S. may be able to read some small letters on the vision chart does not mean she has good vision. In his opinion she may not be able to read the large "E" on the chart, but could read some small letters on the chart. Dr. Schatz's opinion explains how Dr. Farber got H.S. at 20/80 on the Snellen chart. This does not mean she has good vision, she doesn't. It means she gets fleeting glimpses of objects. Dr. Schatz did not express an opinion on the question whether H.S.'s cataract was bad enough to warrant cataract surgery in someone with such extensive macular degeneration. However, in his opinion the angiogram corroborated Dr. Haidt's finding of mild NS changes.

Dr. Hoffer would not tell H.S. she has a 96% chance of improvement with cataract surgery as respondent did. In his opinion it is impossible to tell whether cataract surgery would result in any improvement because of her retinal problem.

The potential acuity meter (PAM) is an instrument that attempts to predict the potentinal for visual acuity of someone with a cataract. Respondent PAMed H.S. to 20/25. Dr. Farber PAMed her at 20/50. The PAM is not reliable in measuring potential acuity in a person with macular degeneration. The PAM reading in such case means some receptors or cones may be capable of functioning at the visual acuity indicated by the PAM. But because the PAM may hit an island of live tissue it does not mean the person's vision will be equal to the PAM reading after surgery. The person may be able to read 20/50 through one little area, as through a straw, but be almost blind. This is particularly true of H.S. who only sees fleeting glimpses of objects and is obviously not capable of 20/25 vision.

Sometime in July 1989 H.S. canceled her cataract surgery respondent had scheduled. Thereafter respondent called H.S.'s son and expressed his disagreement with the cancellation of surgery and tried to convince him H.S. should have the surgery. One of respondent's employees told H.S.'s son that cataract surgery would dramatically improve H.S.'s vision. Respondent also contacted H.S.'s daughter-in-law and was very insistent that cataract surgery should be performed, stating that cataract surgery would do her a lot of good and would definitely improve her vision. Respondent questioned H.S.'s and her family's decision not to have the surgery.

There was some evidence that cataract surgery is contraindicated in cases of macula edema and/or macular degeneration. However, evidence established that such retinal conditions usually are not contraindications for cataract surgery in that such conditions do not preclude the removal of a cataract or increase the risk of complications from surgery. But this does not mean that cataract surgery is appropriate. In this case such surgery would not have been a departure from the standard of care provided that H.S. had a significant cataract and it was

fully explained to her that such surgery might result in very little or no improvement because of her significant retinal condition. If H.S. had been apprised that her vision was severely compromised by a retinal problem for which there is no treatment or correction, and the likely degree of improvement if the surgery is successful, in the manner described by Dr. Farber, then cataract surgery would not be clearly below the standard of practice.

In this case respondent clearly has not met the standard in that he repeatedly expressed strong disagreement with other ophthalmologists' findings and more importantly with the family's decision to cancel surgery. He did not offer cataract surgery with the caveats enunciated by Dr. Farber, instead he urged the family to have the surgery after they had elected not to. His conduct was blatant and unethical.

H.S. did not have a 3.5+NS cataract. Dr. Haidt found a mild NS which Dr. Schatz found consistent with her angiogram. Dr. Chang found a mild NS and Dr. Farber a minimal to moderate NS cataract. Even if H.S. had a significant NS cataract, respondent's conduct was egregious. He not only failed to reveal significant facts to H.S.'s family, he expressly misrepresented the facts to a family faced with a very serious decision: if there was a bad result from surgery H.S. would be essentially blind in both eyes.

X

R.K., a 76 year old female, attended one of respondent's free senior citizen screenings and was referred by one of respondent's technicians to respondent's office for an eye examination. Respondent saw her on January 12, 1989 when she complained of sunlight being very painful. Respondent's office obtained a 20/30 and 20/60 visual acuity and respondent found a 3+NS cataract, right eye, and a mixed cataract (NS, PSE and cortical), left eye. Respondent noted multiple retinal hemorrhage in the left eye and referred her to a retinal specialist for evaluation.

On January 17, 1989 R.K. was examined by Dr. Roger Griffith, a San Jose ophthalmologist and retinal specialist. Dr. Griffith obtained a visual acuity of 20/40 and 20/70 with her glasses (he did not refract her), and found mild NS and cortical changes in the right eye and NS and cortical cataract in the left eye. Dr. Griffith found that R.K. had a history of decreased vision in her left eye since November 1988. His diagnosis was a partial central retinal vein occlusion (CRVO) with cystoid macular edema in the retina. The edema, caused by the CRVO, was mild and non-ischemic. He prescribed baby aspirin to try to prevent further occlusion.

On January 30, 1989 respondent saw R.K. again and scheduled cataract surgery on her left eye. On that date his office obtained a visual acuity of 20/30 and 20/50. Respondent did not examine her macula on January 30 or on February 7, when she returned for a lens calculation necessary for the surgical implant, to determine if any change had occurred in her CRVO or her macular edema. In late February R.K. canceled her scheduled surgery.

On February 24, 1989 R.K. was examined by Dr. David Chang who obtained a visual acuity of 20/30 and 20/80 and found a 1+NS change in the right eye and a 2+NS cataract and a 2+PSE cataract in the left eye. The patient reported poor vision in her left eye commencing in November 1988. Dr. Chang's diagnosis was gross macular edema and a partial CRVO. Dr. Chang recommended against cataract surgery because of such condition.

R.K. experienced a sudden change in her vision in November 1988, which was consistent with the onset of a vein occlusion. It is more likely the reduced vision was caused by a macular problem rather than a cataract. The standard of practice is to wait to see if the CRVO becomes stable or worsens before performing cataract surgery. A partial CRVO can be chronic, can resolve by itself, or can become complete. Most cases resolve but about 30% go on to become complete occlusions. Cataract surgery is definitely contraindicated if the occlusion becomes complete and ischemic.

Dr. Hoffer is of the opinion that in January and February 1989 the percentage of her reduced vision associated with her retinal problem was not known, that no one could tell the amount of improvement she would obtain with cataract surgery; she could obtain some improvement but she could also obtain none.

Dr. Farber opined that cataract surgery would not represent much of a chance for improved vision for R.K., but could reduce the glare she was experiencing. R.K. would have to be told this before being offered cataract surgery.

When Dr. Chang next saw R.K., on June 12, 1989, the CRVO had become complete and ischemic. Her left eye visual acuity was CF. Surgery was subsequently performed to attempt to prevent a more serious eye disease.

Respondent did not wait to see what would happen with R.K.'s retinal conditions, he scheduled her for cataract surgery and scheduled no further examinations of the patient prior to the March 1, 1989 surgery. He did not intend to follow the patient's condition, only to perform cataract surgery.

During an office visit to Dr. Chang, R.K. became upset because respondent had not told her that cataract surgery might not solve her vision problems because of her macular condition. Respondent claims that he informed her of her macular problem, but evidence established that he did not fully disclose to R.K. that she had reduced vision due to CRVO and for that reason it was uncertain whether cataract surgery would improve her vision. Instead, respondent informed her of his usual 96% improvement in vision standard, which was not appropriate for this patient who had a 30% chance her occlusion could become complete. Some of respondent's optimism may have come from the PAM he obtained, 20/25. Evidence was overwhelming that the PAM is unreliable in cases of macular edema. In addition, two of respondent's experts questioned the 20/25 PAM he obtained.

Respondent's conduct in scheduling R.K. for cataract surgery without a full disclosure of her conditions and her chances for improved vision was a departure from the standard of practice of ophthalmology. The standard was to follow the patient over a reasonable period to determine whether the CRVO would resolve or worsen. If it worsened cataract surgery would be contraindicated. If it resolved the ophthalmologist would reassess the patient, including her complaints and her visual acuity, to determine if cataract surgery is appropriate.

XI

There were three major differences of opinion between respondent's expert witnesses and some of complainant's experts. All three were resolved in favor of respondent, as follows:

(a) Standards set forth in Finding IV (d) are those agreed to by respondent's experts. Many ophthalmologists ordinarily would not offer cataract surgery to persons with 20/40 visual acuity and many would not do so for those with 20/50 visual acuity. However, the 20/40 standard, applicable in 1989, is the standard used herein to measure respondent's conduct.

(b) Conflicts in the testimony as to whether cataract surgery is contraindicated when macular problems are present were resolved in respondent's favor.

(c) A conflict in the evidence as to whether it would be appropriate to offer cataract surgery to H.S. was resolved in respondent's favor. The opinion of respondent's experts that cataract surgery could be offered to H.S. under limited circumstances is consistent with the standards set forth in Finding IX.

XII

Respondent called six ophthalmologists to give expert testimony. Four were general ophthalmologists and two specialize in diseases and surgery of the retina and vitreous. Only the four general ophthalmologists rendered opinions on the question whether respondent's conduct constituted gross negligence and/or incompetence. Only one of these four ophthalmologists examined any of the six patients involved in this matter.

Of the two retinal specialists, one, Dr. Griffith, testified only about one patient, R.K., whom he examined in 1989. His findings are included in Finding X herein.

The other retinal specialist, Dr. Howard Schatz, did not examine any of the patients. His testimony was from the records of several of the patients, but primarily concerned H.S. and R.K.

Of the four general ophthalmologists none examined any of the patients involved in this case except for Dr. Farber, who examined one of the patients, H.S.

There was a wide variance in the credentials and the credibility of respondent's experts. One, Dr. Schatz, is perhaps the leading retinal specialist in Northern California. His credentials were impeccable. His objectivity was obvious. His credibility was outstanding.

Dr. Kenneth Hoffer also has impressive credentials, but unfortunately his credibility on the questions whether respondent's conduct constituted gross negligence/incompetence was marred by two factors which rendered his opinions on these questions suspect: (1) Respondent and Dr. Hoffer were medical school classmates and very close friends. They remain good friends. (2) Dr. Hoffer mostly rejected out of hand the findings of other ophthalmologists who examined the patients involved because they were "competing ophthalmologists." For example, Dr. Hoffer was critical of Dr. Chang for giving H.S. informational documents on a low vision clinic because he felt she probably could not read, but he felt she could read respondent's consent to surgery forms. While his bias affected his testimony, particularly on the appropriateness of respondent's scheduling of patients for cataract surgery, much of his testimony was helpful and was fully considered.

Dr. Lawrence O'Dell's qualifications as an expert under California medical standards of practice were compromised by the fact he has never practiced medicine in California. In addition, most of the items listed on his CV were courses he took, not lectures he presented or papers he authored. His

accomplishments in the field would be significant given his lack of having practiced in California. His credibility was seriously flawed by reason of the following:

1. He gave contradictory testimony, e.g., he discounted non-ophthalmologist physician's opinions on the grounds they do not possess the knowledge, training and experience to accurately diagnose and rate cataracts, but he relied upon such opinions when it suited his purpose. He relied on respondent's PAM results where the patient had a macula problem even though he testified the PAM was unreliable in such cases (gave false positives). He disregarded and ridiculed retinal specialists when their opinions or findings were contrary to his, but he relied upon such specialists when consistent with his opinions.

2. He is of the opinion the two ophthalmologists who examined T.H. at the request of the Board's representative were lying. Dr. O'Dell was not present during the testimony of these two expert witnesses, but he reviewed their reports.

3. He is of the opinion that T.H. is lying in reporting that she had no visual problems or complaints. He suggested as a possible reason her Japanese ancestry, believing she may be harboring some resentment over being incarcerated in a camp during World War II. There was no evidence T.H. was interned in a camp and no evidence she was in any way biased or prejudiced against respondent. T.H. was a credible witness. Her credibility was vastly superior to Dr. O'Dell's and respondent's. Dr. O'Dell did not state why any resentment by a Japanese-American over mistreatment 45 years ago would effect her credibility in this case.

4. In Dr. O'Dell's opinion this case is about resentment by university based ophthalmologists over the standards of practice established by "modern" private practice opththalmologists. He believes that university ophthalmologists are angry with and jealous of "advanced" ophthalmologists to the extent they would lie about their findings and perjure themselves in their efforts to attack and discredit a modern ophthalmologist.

5. His poor credibility in general, based on his appearance and demeanor as a witness and the manner in which he responded to questions.

Dr. Joseph Farber, the only ophthalmologist testifying for respondent who examined any of the patients, appeared to make every effort to render honest opinions, although his testimony of H.S.'s visual acuity had one somewhat questionable aspect to it. This is discussed in Finding IX. But generally his credibility was good.

Dr. Michael Kroll's credibility was good but his opinions on the question of respondent's gross negligence/incompetency were based on an acceptance of respondent's version of the facts, including the existence and severity of patients' cataracts, patients' visual acuities, and complaints about their vision.

XIII

(a) A significant portion of respondent's defense in this matter was devoted to attacking or challenging certain practices and/or opinions offered by some of complainant's experts. These attacks were quite apart from the expert's findings in those cases where the expert examined the patient, as well as attacks unrelated to the expert's opinion that respondent's conduct was a departure from the standard of practice of medicine. The subjects involved in these collateral issues were varied and far-ranging; some were interesting, some tedious. However, all involved collateral matters unrelated to the pertinent issues decided in Findings V through X. One or two examples will suffice.

(1) Dr. Paquette's conduct in allowing H.D. some further time (the amount of time was not established) to read the eye chart before a 20/40 and 20/30 acuity was recorded, was roundly condemned by respondent and some of his experts. However, Dr. Farber's conduct in spending 10 minutes with H.S. to obtain a better visual acuity was acceptable to these same critics, based on a so-called distinction between the two patients. This was pure sophistry.

But the primary reason the criticism against Dr. Paquette is of no consequence is that she eventually got the IDENTICAL visual acuity as respondent, 20/40 and 20/30. There is no dispute and no issue.

(2) A great deal of testimony was introduced on the red reflex, with Dr. Stanley receiving the brunt of respondent's criticisms. The gist of the red reflex testimony by Drs. Noortek, Spencer and Stanley, was that if a significant opacity is in the center of the lens the red reflex is ordinarily not as bright red as it is in the absence of the opacity. Conversely, a very bright, strong and clear red reflex is consistent with no significant, dense opacity such as a 3+NS or 4+NS in the center of the lens. Dr. Stanley did not say that the existence of a red reflex indicates no opacity. But with a 4+NS cataract the red reflex is not as bright and clear as it is without the opacity. The standard of practice is that cataracts are detected and rated by clinical examination, not by looking at the red reflex. Dr. Stanley followed such standards in evaluating the three individuals that he examined. He does not determine whether a cataract exists by looking for a red reflex or the absence thereof.

(b) To respondent's claims that the Board's experts engaged in conduct below the standard of practice, the answer is that (1) Such claims were considered in evaluating the qualifications, credibility and opinions expressed by such witnesses; (2) All the crucial standard of practice issues were resolved in respondent's favor (Finding IV (d) and IX); (3) The evidence did not establish respondent's claims. The Board's experts, all testifying in the Board's case in chief, have not been provided the opportunity to answer all of respondent's claims. They would have to be recalled to testify and perhaps additional "independent" experts called to properly resolve all such questions, all taking another 25 or so days of hearing time. But respondent's claims do not involve the important standard of practice issues, resolved in his favor. The answer to the question whether or not one of respondent's experts or one of the Board's experts prescribed the appropriate medication to a patient, is not going to absolve respondent of his conduct found herein, which in each case was established by clear and convincing proof to a reasonable certainty.

(c) Another of respondent's "defenses" to the charges is that the medical indications for cataract surgery taught in medical schools and universities are below the standard of practice, that what is taught in medical school and practiced by the majority of ophthalmologists is a backward, substandard method of practice compared to his practice which involves the use of "modern methodologies." The backward ophthalmologists are jealous of the modern ophthalmologists and are reluctant to bring their practice up to such modern standards.

Whether respondent's charges are merely hyperbole employed to emphasize his disagreement with medical school education, or are a manifestation of an arrogant belief that his practice is not subject to any standards, need not be resolved in this proceeding. For purposes of this matter the standards used to measure respondent's conduct were substantially those suggested by respondent's experts. His defense has no merit.

XIV

(a) Respondent graduated from the Upstate Medical Center, State University of New York, Syracuse, New York, in 1968. After a one year internship and two years as a medical officer in the United States Navy, he completed a three year residency in ophthalmology at the North Shore University Hospital in Manhasset, New York in 1974. He is board certified in ophthalmology.

(b) Respondent has conducted a private practice in ophthalmology in California since 1974, mostly in the San Jose area. The emphasis in his practice was cataract surgery until

1990 when he contends the Board's investigation created adverse publicity which has seriously affected the scope of his practice. Recently he has been doing more refractive surgery for near-sightedness (radial keratotomy). He has performed approximately 2,000 cataract surgeries. He employs two receptionists, two ophthalmological technicians, a surgical counselor, a bookkeeper, and several administrative personnel. Respondent sees approximately 30 patients per day and devotes two days per week to surgery. He practices under two designations: The San Jose Eye Center, also called the San Jose Eye and Cataract Center, and The Cataract Institute of California. The latter is located in the San Jose Eye Center according to respondent's literature which also describes respondent as the Medical Director of The Cataract Institute of California. One of respondent's pamphlets describes him as "a renowned surgeon who is considered to be an innovator of new surgical techniques in Santa Clara County."

(c) Respondent believes strongly in "community service" type programs whereby ophthalmologists go to senior centers and retirement homes to educate seniors by conducting free screenings and providing access to health care for seniors.

From March 1, 1989 to October 31, 1989, respondent's office conducted cataract screenings for 1,100 to 1,300 seniors. Of this number 336 came to his office for an eye examination for which respondent charges a fee. There was no evidence of the number who were recommended or referred for eye examinations. Of the 336, respondent performed cataract surgery on 76. There was no evidence of the number respondent recommended or offered cataract surgery.

(d) Respondent's suggestion that Dr. Stanley elicited no complaints from J.L. and two other patients because Dr. Stanley worded his inquiries in a manner calculated to elicit no complaints, i.e. "You don't have a complaint, do you?" is completely without foundation. Dr. Stanley's credibility was excellent; respondent's was not. Respondent's suggestion is unfounded speculation that seems to illustrate his lack of understanding of the proper role, and the ethical considerations, of a physician in evaluating a patient to determine whether surgery is medically indicated. Perhaps it is also a desperate attempt to explain the tremendous differences in respondent's findings compared to those of the other physicians who examined the same patients, and a realization that this case involves more than a typical difference of opinion among examining physicians. Unfortunately, it does not reflect favorably on respondent.

(e) Respondent's bitterness at patients seeking a second opinion before undergoing surgery demonstrates a lack of understanding of the physician/patient relationship and/or a lack of concern about the patient. The common practice of a

patient facing surgery to seek a second or third opinion would seem especially appropriate for something as important as eye surgery, particularly considering that these patients were scheduled for surgery on their first visit to respondent's office, and before given a reasonable period to reflect on their decision and an opportunity to discuss it with relatives or others. Respondent had never met these patients so there was no long-standing physician/patient relationship or trust which might have precluded the patient seeking another opinion. None of these patients had been referred to respondent by their primary care physician. In most cases the patients logically and appropriately conferred with their primary care physicians following their visits to respondent's office. And in most cases their primary care doctors referred them to another ophthalmologist. Respondent's bitterness extends to the primary care physicians and the ophthalmologists who were consulted for a second opinion. Respondent believes that the charges in the Accusation came about largely because of the jealousies of "competitor" ophthalmologists and some primary care physician's who were in league with his competitors. He believes that other ophthalmologists consider him a "threat" to their practice. Respondent also harbors the unusual belief that if a patient he has scheduled for surgery consults another ophthalmologist, that ophthalmologist will proffer an opinion that cataract surgery is not necessary, but will nevertheless recommend or perform cataract surgery on that patient a few months later. Evidence certainly does not support this accusation. One is hopeful that respondent does not engage in the highly unethical practices he ascribes to his colleagues.

XV

(a) Respondent offered the testimony of several patients on whom he performed cataract surgery during the past few years. All had cataracts and decreased vision in varying degrees. All had complaints about their vision that would warrant cataract surgery. Some also suffered from macular degeneration. All testified that cataract surgery was beneficial, even when the increase in visual acuity was minimal, e.g., by increasing light and their ability to see colors.

(b) On August 27, 1990 T.G., an 83 year old male, went to respondent for an eye examination to see if he needed glasses to pass his driver's license examination. His license was due to expire in December and he would have to pass a vision test to renew it. T.G. did not participate in one of respondent's vision screenings for senior citizens.

After examining T.G. respondent told him "You just failed your driver's test." Respondent told T.G. that he had cataracts in both eyes, that the right eye was bad and that he

should have cataract surgery as soon as possible. Respondent also told T.G. that he had no chance of passing his driver's test without cataract surgery.

At the suggestion of his family T.G. obtained a second opinion from a Dr. Andrews and as a result decided not to have the cataract surgery. He took and passed his driver's test and was issued an unrestricted license.

Respondent acknowledges that he examined T.G., found he had 2+ cataracts in each eye, with 20/50+2 and 20/30+2 distance acuity and 20/30 and 20/30 near vision, and offered him cataract surgery, right eye.

It is not true that one of T.G.'s complaints was that when reading he could no longer tell 6s from 8s. Respondent's testimony of such a complaint was not credible. After reading respondent's reading chart T.G. did state that it was difficult to distinguish 6s from 8s on the reading chart. The chart is in evidence. It is difficult to distinguish some of the fine print numbers on the chart. It would seem highly unusual for a patient to complain to an ophthalmologist of difficulty in distinguishing two or three numbers as opposed to difficulty in reading in general, unless the individual was engaged in a business that required him to read numbers all day. In addition, with 20/30 near vision it would not be within the standard of practice to perform cataract surgery on T.G. to improve his near vision.

The respondent's Personal History form on T.G. contains the following question "Do you now have or have you ever had blurred vision?" with the answer "Yes--left eye--recently." As to such questionnaire evidence clearly established that the writing on the form is not T.G.'s. He did not place the entries upon the form. He did answer questions about his personal health which answers respondent's technician placed on the form. He did not have blurred vision and he did not tell the technician or respondent or any of respondent's employees that he had blurred vision.

The "Complaint" section of respondent's examining record contains references to T.G. being able to read better with his glasses, driving without glasses except at night, eyes watering in the winter but not in the summer, and that his DMV renewal is due in December. Such entries were made by one of respondent's technicians. None of these entries consisted of a complaint by T.G. concerning his vision. After examining T.G. respondent added to the examining record that T.G. can't see fine print, can't tell a 3 from 6 from 8, and "loses golf ball."

In his testimony in this case respondent stated that T.G. had only two complaints, distinguishing 3s, 6s, and 8s in reading fine print and watching a golf ball as it goes over the horizon. Both are accurate, but the numbers "complaint" was not a complaint about his vision, but T.G.'s reaction to the fine print on respondent's reading chart. T.G.'s near vision acuity, 20/30, would not justify cataract surgery to improve near vision. T.G. did state he had trouble seeing a golf ball as it travels over the horizon, but that was not a complaint, or important to T.G., and it clearly does not justify cataract surgery. Later in his testimony respondent claimed that during the course of the examination T.G. complained of blurry vision. This alleged complaint was not noted on the examining record. T.G. denies making such a complaint and it is found that he in fact did not complain of blurry vision.

T.G. is an alert, bright, active individual who plays golf regularly (and plays well); he gardens and drives during the day and night. He does not use his glasses except when necessary to read and to drive at night. He has no trouble seeing and no complaints regarding his vision. At the instant hearing he could easily read the personal history questionnaire without his glasses. T.G.'s credibility was outstanding as judged on the factors listed in Evidence Code section 780. He clearly, cogently and accurately recalled his visit to respondent's office. T.G. had no vision complaints that would justify cataract surgery. Respondent's crude attempt to justify surgery by inventing a complaint of blurred vision was patently false.

DETERMINATION OF ISSUES

I

Cause was established for discipline under the facts set forth in Finding V, under sections 2234(b) (gross negligence), 2234(e) (acts of dishonesty or corruption), and 725 (clearly excessive prescribing or treating) of the Business and Professions Code.

II

Cause was established for discipline under the facts set forth in Finding VI, under sections 2234(b) (gross negligence), 2234(e) (acts of dishonesty or corruption), and 725 (clearly excessive prescribing or treating) of the Business and Professions Code.

III

Cause was established for discipline under the facts set forth in Finding VII, under sections 2234(b) (gross negligence), 2234(e) (acts of dishonesty or corruption), and 725

(clearly excessive prescribing or treating) of the Business and Professions Code.

IV

Cause was established for discipline under the facts set forth in Finding IX, under sections 2234(b) (gross negligence), 2234(e) (acts of dishonesty or corruption), and 725 (clearly excessive prescribing or treating) of the Business and Professions Code.

V

Cause was established for discipline under the facts set forth in Findings V, VI, VII, VIII, IX and X, under section 2234(c) (repeated negligent acts) of the Business and Professions Code.

VI

Evidence did not establish that respondent's conduct set forth in the Findings arose out of any deficiencies in his knowledge or ability. The charges of incompetence were not proven.

VII

The T.G. incident (Finding XV) raises some disturbing questions about respondent's fitness for licensure and the danger he poses to the public. This incident was consistent with respondent's conduct found with respect to patients H.L, J.L, and T.H. His attempt to exploit them when they had no vision complaints and no cataracts was a blatant violation of the public trust by a licensee in whom members of the public must of necessity place their ultimate faith and trust. In addition, respondent has attempted to evade all consequences for his conduct by a complete denial rather than by assuming responsibility for his actions.

Because respondent places the blame for his problems on other physicians, it is noteworthy that the T.G. matter did not come to the Board's attention from a physician. T.G. notified the Board of his experience. No "competing" physician and no Board designated physician testified about T.G.

VIII

Also disturbing are respondent's notions about "competitor physicians," who he asserts use devious and unethical practices in obtaining patients and in complaining about his practice. Evidently competitors include everyone who sees

a patient whom respondent previously examined and who disagrees with respondent's findings, as well as those with whom respondent vies for patients. He has falsely accused Lens Crafters, a dispensing optician, of referring patients to other ophthalmologists.

The legalization of advertising and related changes in the rules regulating the medical profession may have led some to view the profession as authorizing competitive, cut throat tactics, with a concept of the profession that includes abandonment of many of the principles that have distinguished medical practitioners from aluminum siding salesmen. Respondent's concept of his profession may be dangerously close to this view and may have motivated some of his actions as well as a paranoid type resentment toward colleagues. The welfare of his patients as his principle concern is a missing ingredient in his practice.

IX

The Accusation herein charges respondent with violating section 2234 of the Business and Professions Code by aiding and abetting and encouraging Lens Crafters to violate section 2556 of the Code. However, the language in 2234 authorizing discipline for aiding and abetting refers to assisting in or abetting the violation of "any provision of this chapter." Section 2234 is part of Chapter 5 of Division 2 of the Code while section 2556 is found in a different chapter, Chapter 5.5. Therefore respondent is not subject to discipline under 2234(a) by virtue of violating 2556. In light of this Determination no detailed findings are made with respect to respondent's conduct regarding the Lens Crafters matter, and no rulings are made on the other defenses raised by respondent in connection with this charge.

ORDER

1. For cause for discipline set forth in Determination I, respondent's license is revoked.

2. For cause for discipline set forth in Determination II, respondent's license is revoked.

3. For cause for discipline set forth in Determination III, respondent's license is revoked.

4. For cause for discipline set forth in Determination IV, respondent's license is revoked.

5. For cause for discipline set forth in Determination V, respondent's license is revoked.

The above orders of revocation are stayed and respondent is placed on probation for seven years upon the following terms and conditions:

1. Within 30 days of the effective date of this decision, respondent shall submit to the Division for its prior approval a course in Ethics, which respondent shall successfully complete during the first year of probation.

2. Within 30 days of the effective date of this decision, respondent shall submit to the Division for its prior approval a plan of practice in which respondent's practice shall be monitored by another physician in respondent's field of practice, who shall provide periodic reports to the Division. The monitor shall be selected by the Division.

   As a minimum the plan of practice shall include the elements set forth in condition 3 below and provision for the training of respondent's ophthalmological technicians and assistants in record keeping, testing for visual acuity, ethics and other matters specified by the Division.

   If the monitor resigns or is no longer available, respondent shall, within 10 days, notify the Division so that a new monitor may be appointed by the Division.

3. Respondent shall not offer cataract surgery and/or lens implantation to a patient and shall not perform or assist in any such surgery without first preparing and maintaining full and complete documentation that such surgery is within the standard of practice guidelines set forth in Finding IV(d) herein. The visual acuity standard shall be 20/50 or worse.

   The patient's complaints that constitute the reasons for such surgery shall be set forth in detail on a separate document or writing maintained by respondent. A copy of this document shall be provided the patient and the patient's legal guardian, if any, prior to the scheduling of any surgery.

   Prior to scheduling cataract surgery respondent shall list on his examining record or on a separate document all known conditions, other than cataracts, that are affecting the patient's

vision. If the patient suffers from any known condition, other than cataracts, that could be a cause or one of the causes of the patient's decreased vision, prior to scheduling surgery respondent shall advise the patient in writing of the condition, how it is or could be affecting the patient's vision, whether such condition is reversible and if treatable, the treatment and prognosis, and the specific prognosis for improvement with cataract surgery. The writing shall be in ordinary and concise language understandable to a layperson.

Any document or writing required to be made or kept under this condition shall be subject to inspection by the Division or its designee. Upon request the respondent shall promptly provide the Division or its designee with a copy of any such document.

Respondent shall not perform cataract surgery on any patient until the monitor or other ophthalmologist approved by the Division has had an opportunity to review respondent's records concerning the patient, including those provided for herein, and has approved the scheduled surgery. The monitor or other ophthalmologist approved by the Division may, prior to surgery, examine the patient to determine whether the patient has a cataract which significantly interferes with the patient's activities and lifestyle, and wishes to undergo cataract surgery and lens implantation.

4. Respondent shall not provide or offer to any employee or member of his staff any bonus, incentive, or similar consideration based in whole or in part on the number of cataract surgeries offered or performed.

5. Respondent shall obey all federal, state and local laws, and all rules governing the practice of medicine in California.

6. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Division, stating whether there has been compliance with all the conditions of probation.

7. Respondent shall comply with the Division's probation surveillance program.

8. Respondent shall appear in person for interviews with the Division's medical consultant upon request at various intervals and with reasonable notice.

9. The period of probation shall not run during the time respondent is residing or practicing outside the jurisdiction of California. If, during probation, respondent moves out of the jurisdiction of California to reside or practice elsewhere, respondent is required to immediately notify the Division in writing of the date of departure, and the date of return, if any.

10. Upon successful completion of probation, respondent's certificate will be fully restored. If respondent violates probation in any respect, the Division, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an accusation or petition to revoke probation is filed against respondent during probation, the Division shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

DATED: July 31, 1991.

ROBERT R. COFFMAN
Administrative Law Judge

RRC:lhj

REDACTED

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BEFORE THE
DIVISION OF MEDICAL QUALITY
BOARD OF MEDICAL QUALITY ASSURANCE
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	NO. D-4090
GILBERT J. ELIAN, M.D. 4585 Stevens Creek Blvd., #100 Santa Clara, CA 95051 Certificate No. G26558 Respondent.	**ACCUSATION**

KENNETH J. WAGSTAFF, complainant herein, charges and alleges as follows:

1. He is the Executive Director of the Board of Medical Quality Assurance, State of California (hereinafter "the Board") and makes these charges and allegations solely in his official capacity.

2. At all times material herein, respondent Gilbert J. Elian, M.D. (hereinafter "respondent") has held physician and surgeon certificate No. G26558, which was issued to him by the Board on or about April 2, 1974. Said certificate is in good

standing at the present time. No prior disciplinary action has been taken against said certificate.

3. Section 2001 of the Business and Professions Code[1/] (hereinafter referred to as the "code") provides for the existence of the board.

4. Section 2003 provides for the existence of the Division of Medical Quality (hereinafter referred to as the "division") within the board.

5. Section 2004 provides, inter alia, that the division is responsible for the administration and hearing of disciplinary actions involving enforcement of the Medical Practice Act (section 2000 et seq.) and the carrying out of disciplinary action appropriate to findings made by a medical quality review committee, the division, or an administrative law judge with respect to the quality of medical practice carried out by physician & surgeon certificate holders.

6. Section 2220, 2234 and 2227 together provide that the division shall take disciplinary action against the holder of a physician's and surgeon's certificate who is guilty of unprofessional conduct.

7. Section 2234 provides in part, as follows:

> The Division of Medical Quality shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article,

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1. All statutory references are to the Business and Professions Code unless otherwise indicated.

unprofessional conduct includes, but is not limited to the following:

(a) Violating or attempting to violate, directly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this chapter.

(b) Gross negligence.

(c) Repeated negligent acts.

(d) Incompetence.

(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

8. Section 725 provides, in part, that repeated acts of clearly excessive prescribing or administering of drugs or treatment or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the local commundity of licensees is unprofessional conduct for a physician and surgeon.

9. Section 2262 provides that altering or falsifying the medical record of any person, or creating any false medical record, with fraudulent intent, constitutes unprofessional conduct.

10. At all times mentioned hereinafter, respondent practiced as a physician at and held an ownership interest in San

Jose Eye Center, 4585 Stevens Creek Boulevard, Santa Clara, CA 95051.

11. Respondent is subject to disciplinary action in that respondent has committed violations of Business and Professions Code sections 2234(a), (b), (c), (d) and/or (e), and/or 725, and/or 2262 in connection with the care and treatment of patients at San Jose Eye Center as more particularly alleged hereinbelow:

(A) On or about April 18, 1989, J[redacted] L[redacted], 88 years of age, (DOB [redacted]) and his wife H[redacted] L[redacted], 91 years of age, (DOB [redacted]) were seen by agents or employees of San Jose Eye Center at the Senior Citizen Center in Mountain View. Said agents or employees were providing free eye examinations for senior citizens. Neither of the L[redacted] were experiencing any problems with vision, however both agreed to be examined further by a physician.

(B) Approximately two weeks thereafter, a small bus came to pick up the L[redacted] and transported them to San Jose Eye Center along with other senior citizens.

(C) Thereafter, both Mr. and Mrs. L[redacted] were examined by respondent who diagnosed both Mr. and Mrs. L[redacted] as having cataracts, and entered or caused to be entered said diagnoses and related findings in said patients' medical records.

(D) Thereafter, respondent scheduled both Mr. and Mrs. L[redacted] for cataract surgery on an outpatient basis at San Jose Eye Center for on or about May 2, 1989.

(E) Mr. and Mrs. L[redacted], however, did not have said cataract surgery after being subsequently advised by both their personal physician and another opthalmologist that said cataract surgery was not necessary nor warranted.

(F) In truth and in fact, neigher Mr. nor Mrs. L[redacted] had any significant lens opacities which would warrant cataract surgery.

FIRST CAUSE FOR DISCIPLINARY ACTION

12. Respondent's conduct as set forth in paragraphs 11(A) through 11(F) hereinabove constitutes gross negligence and/or incompetence pursuant to sections 2234(b) and/or (d).

SECOND CAUSE FOR DISCIPLINARY ACTION

13. The allegations of paragraphs 11(A) through 11(F) are incorporated herein by reference.

14. Respondent's conduct, as described in paragraphs 11(A) through 11(F) constitutes repeated negligent acts pursuant to section 2234(c).

THIRD CAUSE FOR DISCIPLINARY ACTION

15. The allegations of paragraphs 11(A) through 11(F) are incorporated herein by reference.

16. Respondent's conduct, as described in paragraphs 11(A) through 11(F) involved the alteration or falsification of medical records with fraudulent intent and therefore is cause for disciplinary action pursuant to sections 2262 and 2234.

FOURTH CAUSE FOR DISCIPLINARY ACTION

17. The allegations of paragraphs 11(A) through 11(F) are incorporated herein by reference.

18. Respondent's conduct, as described in paragraphs 11(A) through 11(F) constitutes the commission of an act(s) involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and is therefore cause for discipline pursuant to section 2234(e).

FIFTH CAUSE FOR DISCIPLINARY ACTION

19. Respondent's conduct as set forth in paragraphs 11(A) through 11(F) constitutes repeated acts of clearly excessive prescribing or administering of treatment as determined by the standard of the local community of licensees pursuant to section 725.

WHEREFORE, complainant requests that a hearing be held and that thereafter the Board issue an order:

1. Revoking or suspending respondent's physician and surgeon's certificate number G-26558;

2. Prohibiting respondent from supervising physician's assistants; and,

3. Taking such other and further action as is deemed just and proper.

DATED: October 11, 1989

KENNETH J. WAGSTAFF
Executive Director
Board of Medical Quality Assurance
State of California

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Attorneys for Complainant

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
STATE OF CALIFORNIA

In the Matter of the First Supplemental Accusation Against:	NO. D-4090
GILBERT J. ELIAN, M.D. 4585 Stevens Creek Blvd., #100 Santa Clara, CA 95051 Certificate No. G26558 Respondent.	FIRST SUPPLEMENTAL ACCUSATION

KENNETH J. WAGSTAFF, complainant herein, charges and alleges as follows:

20. He is the Executive Director of the Medical Board of California[1/], State of California (hereinafter "the Board") and makes these charges and allegations solely in his official capacity.

21. This first supplemental accusation constitutes an addendum to accusation number D-4090 filed heretofore against

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1. Effective January 1, 1990, the Board of Medical Quality Assurance was renamed Medical Board of California. (Bus. & Prof. Code §2001)

Gilbert J. Elian, M.D., (hereinafter "respondent") and executed on October 11, 1989, by complainant.

22. At all times material herein, respondent has held physician and surgeon certificate No. G26558, which was issued to him by the Board on or about April 2, 1974. Said certificate is in good standing at the present time.

23. At all times mentioned hereinafter, respondent practiced as a physician at and held an ownership interest in San Jose Eye Center, 4585 Stevens Creek Boulevard, Santa Clara, CA 95051.

PATIENT RUTH KELLY

24. Respondent is further subject to disciplinary action in that respondent has committed violations of Business and Professions Code sections 2234(a), (b), (c), (d) and/or (e), and/or 725, and/or 2262 in connection with the care and treatment of patient R[redacted] K[redacted] at San Jose Eye Center as more particularly alleged hereinbelow:

(A) On or about January 12, 1989, R[redacted] K[redacted] 76 years of age, was seen by respondent at San Jose Eye Center.

(B) Thereafter, respondent scheduled Ms. K[redacted] for cataract surgery on an outpatient basis at San Jose Eye Center for on or about March 1, 1989.

(C) Ms. K[redacted], however, did not have said cataract surgery after being subsequently advised by another opthalmologist that said cataract surgery was not necessary nor warranted, and, in fact, contraindicated due to macular edema.

(D) In truth and in fact, Ms. K[redacted] did not have cataracts to a degree which would warrant cataract surgery, and/or, cataract surgery was contraindicated due to macular edema.

SIXTH CAUSE FOR DISCIPLINARY ACTION

25. Respondent's conduct as set forth in paragraphs 24(A) through 24(D) hereinabove constitutes gross negligence and/or incompetence pursuant to sections 2234(b) and/or (d).

SEVENTH CAUSE FOR DISCIPLINARY ACTION

26. The allegations of paragraphs 24(A) through 24(D) are incorporated herein by reference.

27. Respondent's conduct, as described in paragraphs 24(A) through 24(D) constitutes repeated negligent acts pursuant to section 2234(c).

EIGHTH CAUSE FOR DISCIPLINARY ACTION

28. The allegations of paragraphs 24(A) through 24(D) are incorporated herein by reference.

29. Respondent's conduct, as described in paragraphs 24(A) through 24(D) constitutes the commission of an act(s) involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and is therefore cause for discipline pursuant to section 2234(e).

NINTH CAUSE FOR DISCIPLINARY ACTION

30. Respondent's conduct as set forth in paragraphs 24(A) through 24(D) constitutes repeated acts of clearly excessive prescribing or administering of treatment as determined

by the standard of the local community of licensees pursuant to section 725.

PATIENT H[redacted] S[redacted]

31. Respondent is further subject to disciplinary action in that respondent has committed violations of Business and Professions Code sections 2234(a), (b), (c), (d) and/or (e), and/or 725, and/or 2262 in connection with the care and treatment of patient H[redacted] S[redacted] at San Jose Eye Center as more particularly alleged hereinbelow:

(A) On or about June 28, 1989, H[redacted] S[redacted], 85 years of age, was examined by respondent at San Jose Eye Center.

(B) Thereafter, respondent scheduled Ms. S[redacted] for cataract surgery on an outpatient basis at San Jose Eye Center for on or about July 20, 1989.

(C) Ms. S[redacted], however, did not have said cataract surgery after being subsequently advised by another opthalmologist that said cataract surgery was not necessary nor warranted and in fact contraindicated due to senile macular degeneration.

(D) In truth and in fact, Ms. S[redacted] did not have cataracts to a degree which would warrant cataract surgery, and/or cataract surgery was contraindicated in light of senile macular degeneration.

TENTH CAUSE FOR DISCIPLINARY ACTION

32. Respondent's conduct as set forth in paragraphs 31(A) through 31(D) hereinabove constitutes gross negligence and/or incompetence pursuant to sections 2234(b) and/or (d).

ELEVENTH CAUSE FOR DISCIPLINARY ACTION

33. The allegations of paragraphs 31(A) through 31(D) are incorporated herein by reference.

34. Respondent's conduct, as described in paragraphs 31(A) through 31(D) constitutes repeated negligent acts pursuant to section 2234(c).

TWELFTH CAUSE FOR DISCIPLINARY ACTION

35. The allegations of paragraphs 31(A) through 31(D) are incorporated herein by reference.

36. Respondent's conduct, as described in paragraphs 31(A) through 31(D) constitutes the commission of an act(s) involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and is therefore cause for discipline pursuant to section 2234(e).

THIRTEENTH CAUSE FOR DISCIPLINARY ACTION

37. Respondent's conduct as set forth in paragraphs 31(A) through 31(D) constitutes repeated acts of clearly excessive prescribing or administering of treatment as determined by the standard of the local community of licensees pursuant to section 725.

PATIENT H[redacted] D[redacted]

38. Respondent is further subject to disciplinary action in that respondent has committed violations of Business and Professions Code sections 2234(a), (b), (c), (d) and/or (e), and/or 725, and/or 2262 in connection with the care and treatment of patient H[redacted] D[redacted] at San Jose Eye Center as more particularly alleged hereinbelow:

(A) In or about May, 1989, H[redacted] D[redacted], 86 years of age, (DOB [redacted]) was seen by agents or employees of San Jose Eye Center at a trailer court in Mountain View. Said agents or employees were providing free eye examinations for senior citizens. D[redacted] was not experiencing any problems with vision, however she agreed to be examined further by a physician.

(B) On or about May 10, 1989, D[redacted] was transported by San Jose Eye Center to San Jose Eye Center along with other senior citizens.

(C) Thereafter, D[redacted] was examined by respondent who advised D[redacted] that she should have cataract surgery.

(D) Thereafter, respondent scheduled Ms.D[redacted] for cataract surgery on an outpatient basis at San Jose Eye Center for on or about June 1, 1989.

(E) Ms. D[redacted], however, did not have said cataract surgery after being subsequently advised by both her personal physician and another opthalmologist that said cataract surgery was not necessary nor warranted.

(F) In truth and in fact, Ms. D[redacted] did not have cataracts to a degree which would warrant cataract surgery.

FOURTEENTH CAUSE FOR DISCIPLINARY ACTION

39. Respondent's conduct as set forth in paragraphs 38(A) through 38(F) hereinabove constitutes gross negligence and/or incompetence pursuant to sections 2234(b) and/or (d).

FIFTEENTH CAUSE FOR DISCIPLINARY ACTION

40. The allegations of paragraph 38(A) through 38(F) are incorporated herein by reference.

41. Respondent's conduct, as described in paragraphs 38(A) through 38(F) constitutes repeated negligent acts pursuant to section 2234(c).

SIXTEENTH CAUSE FOR DISCIPLINARY ACTION

42. The allegations of paragraphs 38(A) through 38(F) are incorporated herein by reference.

43. Respondent's conduct, as described in paragraphs 38(A) through 38(F) constitutes the commission of an act(s) involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and is therefore cause for discipline pursuant to section 2234(e).

SEVENTEENTH CAUSE FOR DISCIPLINARY ACTION

44. Respondent's conduct as set forth in paragraphs 38(A) through 38(F) constitutes repeated acts of clearly excessive prescribing or administering of treatment as determined by the standard of the local community of licensees pursuant to section 725.

EIGHTEENTH CAUSE FOR DISCIPLINARY ACTION

45. The allegations of the First, Sixth, Tenth, and Fourteenth causes of action set forth hereinabove are incorporated herein by reference.

46. Respondent's conduct as set forth in said causes of action together constitute gross negligence and/or incompetence pursuant to sections 2234(b) and/or (d).

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NINETEENTH CAUSE FOR DISCIPLINARY ACTION

47. The allegations of the Second, Seventh, Eleventh, and Fifteenth causes of action set forth hereinabove are incorporated herein by reference.

48. Respondent's conduct, as described in said causes of action together constitute repeated negligent acts pursuant to section 2234(c).

TWENTIETH CAUSE FOR DISCIPLINARY ACTION

49. The allegations of the Fifth, Ninth, Thirteenth, and Seventeenth causes of action set forth hereinabove are incorporated herein by reference.

50. Respondent's conduct as set forth in said causes of action together constitute repeated acts of clearly excessive prescribing or administering of treatment as determined by the standard of the local community of licensees pursuant to section 725.

WHEREFORE, complainant requests that a hearing be held and that thereafter the Board issue an order:

1. Revoking or suspending respondent's physician and surgeon's certificate number G-26558;

2. Prohibiting respondent from supervising physician's assistants; and,

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3. Taking such other and further action as is deemed just and proper.

DATED: April 9, 1990

KENNETH J. WAGSTAFF
Executive Director
MEDICAL BOARD OF CALIFORNIA
State of California

REDACTED

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Attorneys for Complainant

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
STATE OF CALIFORNIA

In the Matter of the Second Supplemental Accusation Against:	NO. D-4090
GILBERT J. ELIAN, M.D. 4585 Stevens Creek Blvd., #100 Santa Clara, CA 95051 Certificate No. G26558 Respondent.	SECOND SUPPLEMENTAL ACCUSATION

KENNETH J. WAGSTAFF, complainant herein, charges and alleges as follows:

51. He is the Executive Director of the Medical Board of California[1/], State of California (hereinafter "the Board") and makes these charges and allegations solely in his official capacity.

52. This second supplemental accusation constitutes an addendum to accusation and first supplemental accusation numbers

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1. Effective January 1, 1990, the Board of Medical Quality Assurance was renamed Medical Board of California. (Bus. & Prof. Code §2001)

D-4090 filed heretofore against Gilbert J. Elian, M.D., (hereinafter "respondent") and executed on October 11, 1989, and April 9, 1990, respectively, by complainant.

53. At all times material herein, respondent has held physician and surgeon certificate No. G26558, which was issued to him by the Board on or about April 2, 1974. Said certificate is in good standing at the present time.

54. At all times mentioned hereinafter, respondent practiced as a physician at and held an ownership interest in San Jose Eye Center, 4585 Stevens Creek Boulevard, Santa Clara, CA 95051.

PATIENT T[redacted] H[redacted]

55. Respondent is further subject to disciplinary action in that respondent has committed violations of Business and Professions Code sections 2234(a), (b), (c), (d) and/or (e), and/or 725, and/or 2262 in connection with the care and treatment of patient T[redacted] H[redacted] at San Jose Eye Center as more particularly alleged hereinbelow:

(A) In or about August, 1989, T[redacted] H[redacted], 81 years of age, (DOB [redacted]) was seen by agents or employees of San Jose Eye Center at a Senior Citizen Center in San Jose. Said agents or employees were providing free eye examinations for senior citizens. H[redacted] was not complaining about nor experiencing any significant problems with vision, however she agreed to be examined further by a physician.

(B) On or about August, 1989, H[redacted] was transported by San Jose Eye Center to San Jose Eye Center along with other senior citizens.

(C) Thereafter, H[redacted] was examined by respondent who advised H[redacted] that she should have cataract surgery.

(D) Thereafter, respondent scheduled H[redacted] for cataract surgery on an outpatient basis at San Jose Eye Center for on or about September 21, 1989.

(E) Ms. H[redacted], however, did not have said cataract surgery after being subsequently advised by another opthalmologist that said cataract surgery was not necessary nor warranted.

(F) In truth and in fact, Ms. H[redacted] did not have cataracts to a degree which would warrant cataract surgery.

21ST CAUSE FOR DISCIPLINARY ACTION

56. Respondent's conduct as set forth in paragraphs 55(A) through 55(F) hereinabove constitutes gross negligence and/or incompetence pursuant to sections 2234(b) and/or (d).

22ND CAUSE FOR DISCIPLINARY ACTION

57. The allegations of paragraphs 55(A) through 55(F) are incorporated herein by reference.

58. Respondent's conduct, as described in paragraphs 55(A) through 55(F) constitutes repeated negligent acts pursuant to section 2234(c).

23RD CAUSE FOR DISCIPLINARY ACTION

59. The allegations of paragraphs 55(A) through 55(F) are incorporated herein by reference.

60. Respondent's conduct, as described in paragraphs 55(A) through 55(F) constitutes the commission of an act(s) involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and is therefore cause for discipline pursuant to section 2234(e).

24TH CAUSE FOR DISCIPLINARY ACTION

61. Respondent's conduct as set forth in paragraphs 55(A) through 55(F) constitutes repeated acts of clearly excessive prescribing or administering of treatment as determined by the standard of the local community of licensees pursuant to section 725.

25TH CAUSE FOR DISCIPLINARY ACTION

62. The allegations of the First, Sixth, Tenth, Fourteenth and 21st causes of action set forth hereinabove are incorporated herein by reference.

63. Respondent's conduct as set forth in said causes of action together constitutes gross negligence and/or incompetence pursuant to sections 2234(b) and/or (d).

26TH CAUSE FOR DISCIPLINARY ACTION

64. The allegations of the Second, Seventh, Eleventh, Fifteenth and 22nd causes of action set forth hereinabove are incorporated herein by reference.

65. Respondent's conduct, as described in said causes of action together constitute repeated negligent acts pursuant to section 2234(c).

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27TH CAUSE FOR DISCIPLINARY ACTION

66. The allegations of the Fifth, Ninth, Thirteenth, Seventeenth and 24th causes of action set forth hereinabove are incorporated herein by reference.

67. Respondent's conduct, as set forth in said causes of action together constitute repeated acts of clearly excessive prescribing or administering of treatment as determined by the standard of the local community of licensees pursuant to section 725.

LENS CRAFTERS

Business and Professions Code section 2556 provides, that for registered dispensing opticians, it is unlawful to do any of the following: to advertise the furnishing of, or to furnish, the services of a refractionist, an optometrist, or a physician and surgeon; to directly or indirectly employ or maintain on or near the premises used for optical dispensing, a refractionist, an optometrist, a physician and surgeon, or a practitioner of any other profession for the purpose of any examination or treatment of the eyes; or to duplicate or change lenses without a prescription or order from a person duly licensed to issue the same.

28TH CAUSE FOR DISCIPLINARY ACTION

69. Respondent is further subject to disciplinary action in that respondent has committed unprofessional conduct pursuant to Business and Professions Code section 2234 as more particularly alleged hereinafter.

A) Prior to November 22, 1989, agents or employees of respondent approached "Lens Crafters" a registered dispensing optician located at Valley Fair Shopping Center, 2855 Stevens Creek Blvd., Ste 2242, Santa Clara, CA and proposed setting up a cataract screening table on the premises of Lens Crafters.

B) On or about November 22, 1989, agents and employees of respondent appeared at Lens Crafters, in white medical smocks with various types of equipment including eye examination equipment, a patient screening chair, a television video with a video tape relating to cataract surgery, cataract and eye surgery brochures, and a large photograph of respondent which was displayed on a small table covered with a black velour table cloth.

C) Said agents or employees of respondent set up screening in the corner of the Lens Crafters facility from which numerous patients were examined and screened throughout the day.

D) Respondent is guilty of unprofessional conduct in that he aided and abetted and encouraged Lens Crafters to violate Business and Professions Code section 2556.

WHEREFORE, complainant requests that a hearing be held and that thereafter the Board issue an order:

1. Revoking or suspending respondent's physician and surgeon's certificate number G-26558;

2. Prohibiting respondent from supervising physician's assistants; and,

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3. Taking such other and further action as is deemed just and proper.

DATED: September 14, 1990

KENNETH J. WAGSTAFF
Executive Director
MEDICAL BOARD OF CALIFORNIA
State of California